Carolina ACCESS Enrollment Form for Medicaid Recipients

(Use Health Choice Enrollment form if enrolling a child with Health Choice in Carolina ACCESS)

Explain the advantages and benefits of Carolina ACCESS to all Medicaid recipients enrolled or potentially enrolled in Carolina ACCESS.

Date: _____County: _____ Preferred Language: _____

Person completing the form: _____

❑ DSS ❑ Primary Care Provider ❑ Other _____

Case head: _____ MID: _____
Address:

_____
Street City Zip

Telephone #: _____ Cell # _____Email:_____

	Person to be Enrolled	Date of Birth	MID	Name of primary care provider	Medicaid ID of Provider
1					
2					
3					
4					
5					

Specify any health care needs (i.e., asthma, diabetes, heart disease). If none, put N/A
(Numbers below correspond to above number of person being enrolled)

1_____

2_____

3_____

4_____

5_____

❑ Transportation to doctor needed ❑ Referred for county transportation

❑ Handbook provided at time of interview ❑ Handbook mailed to head of household

SIGNATURE OF PATIENT OR HEAD OF HOUSEHOLD IF PATIENT IS A MINOR:

_____ DATE: _____

(By signing, I certify that I have received an explanation of Carolina ACCESS and my freedom to choose a participating provider)

Division of Medical Assistance
Community Care of North Carolina/Access Care

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